Mantis
Counseling and Coaching Services, LLC

Demographic Information

Please fill out this form completely and print clearly.

Full Name _____ Date of birth _____/_____/_____

Social Security Number _____/_____/_____ Address _____

Relationship status _____ Gender _____

Home phone _____ Cell phone _____

Contact preference (where messages may be left): _____

Insurance information: Please provide copies, front and back, of all insurance cards

Primary Insurance _____

Address _____ Phone _____

Policy ID # _____ Group #_____

City/State/Zip Code _____

Policy holder's name _____ Date of birth _____/_____/_____

Employer's name _____ Address _____

City/State/Zip Code _____

Other Insurance _____

Address _____ Phone _____

Policy ID # _____ Group # _____

Policy Holder Information _____

City/State/Zip Code _____

Primary Care Physician _____ Phone # _____

Address _____ City/State/Zip Code _____

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Informed Consent for Psychological Treatment

(Initial indicates you have read and understood this section _____)

I hereby give my consent for psychological treatment form myself (or my dependant) by Mantis Counseling and Coaching Services, LLC. Treatment may include talk psychotherapy, experiential psychotherapy, and mindfulness training to me/my dependant.

I am entering into psychotherapy with full understanding, participation, and consent. I authorize the therapist to carry out psychological and psychotherapeutic exams, treatment and diagnostic procedures which become advisable now or during the course of my treatment. I understand the purposes of these procedures will be explained to me upon my request, and they are subject to my agreement.

I understand that while the course of my treatment is designed to be helpful, my therapist can make no guarantees regarding the outcome of my treatment. Furthermore, I understand that the psychotherapy process can bring up uncomfortable feelings and reactions, such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences, and these reactions will be worked on between the therapist and myself during our regularly scheduled sessions.

I understand that my therapist is responsible for maintaining all professional standards set forth by the ethical principles of the professional associations as well as the laws of the state of Colorado governing the practice of psychotherapy and that she is liable for infractions of those standards. I agree to address any grievances I may have directly with my therapist immediately.

I understand that my therapist, from time to time, makes teaching and research contributions using disguised client material. By consenting to treatment, I am giving consent to this process of professional contribution and the right to use disguised materials without financial remuneration.

Receipt of Privacy Practices Form

(Initial indicates you have read and understood this section _____)

I hereby acknowledge that I have been provided with the Privacy Practices Form. I understand that my protected health information can be used for the purposes of treatment, payment, and health care operations. I understand that my protected health information may be disclosed as mandated by law and without my authorization in the following instances: child abuse and neglect, threats to the health and safety of self and others, social security administrative functions, and judicial procedures.

Judicial Procedures Clause

(Initial indicates you have read and understood this section _____)

I understand that I must produce information about any upcoming court cases that may involve my therapist's testimony prior to treatment or at my earliest knowledge of such

an event. I understand that I will be fully responsible for any and all legal fees incurred by the therapist as requested by me or my attorney regarding my course of treatment. Court appearances, witness testimony, gathering information for court, court transportation costs, parking fees, costs for waiting to appear in court, mileage to and from court, and any other fees related to judicial proceedings will be charged to me personally at the rate of $250.00 per hour. Any day a therapist is subpoenaed to court, a minimum of two hours at the above rate is expected on any day of testimony.

I hereby acknowledge that I will not use these psychological treatment services for the purposes of building a case in court or for the purposes of fulfilling a court requirement for treatment. I understand that this may be grounds for termination of services if I do not fully disclose any judicial proceedings that may effect or be affected by my treatment.

Insurance and other Third Party Payers

(Initial indicates you have read and understood this section _____)

Attention: Even if you have health care insurance, it is ultimately your responsibility for payment in full upon receipt of services.

I understand that I am responsible for understanding my health insurance policy requirements and benefits for mental health services. Most insurance companies will have a disclaimer that authorization of services does not guarantee payment of services. Also, the actual co-pay required of me may differ from the stated amount after the insurance company processes the claim. In addition, I may have a deductible I must meet before my insurance covers any charges, and myinsurance may only cover a percentage of the charge, which can change after a certain number of sessions. I understand that I am expected to cover the cost of all services at the time of treatment, and must request the balance from my insurer.

Fees for Services

(Initial indicates you have read and understood this section _____)

Mantis Counseling and Coaching, LLC has a general fee of $120.00 per 50 minute session of psychotherapy. Payment is expected in full at the time the service is rendered. Failure of payment may result in account being sent into collection. Please speak with your therapist if there is some extenuating circumstance regarding immediate payment.

Communication between client and therapist between sessions will be by telephone, and all changes must be confirmed with a return phone message. Calls for purposes other than information or scheduling will be charged in quarter-hour increments of the full session fee (i.e. 15 minutes = 25% of full fee).

I understand that I am contracting for units of clinician time which cannot be scheduled for anyone else unless I give sufficient advance notice of cancellation in order to reschedule that time. I agree to pay full price per scheduled hour unless I have given 24 hours notice, in which case this “no show” fee will be waived. If the therapist cancels with less than 24 hours notice

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without a verified emergency, I understand that I will receive a session free of charge. (Monday appointments must be cancelled by noon on the proceeding Friday).

Psychotherapist's Availability

(Initial indicates you have read and understood this section _____)

The therapist is often not immediately available by telephone, but has voicemail that is monitored frequently. The therapist will make every effort to return phone calls within one business day. If you will be difficult to reach, please leave information about availability in your message. If the therapist will be unavailable for an extended period of time, you will be provided with a colleague to contact, if necessary. Dates of vacations and exceptions will be discussed with you in advance. If you are unable to contact your therapist and cannot wait for them to return your call and feel you are in an mental health emergency situation, please contact your physician or the nearest emergency room and ask for the mental health worker on-site. You may also contact 911.

Termination of Treatment

(Initial indicates you have read and understood this section _____)

The therapist may terminate treatment for the following reasons: if payment is not timely, if the client is not compliant with recommended treatment (such as seeking consultation, refraining from dangerous practices, coming to sessions under the influence, etc.), if the client drops out of treatment without therapist's recommendation for over three months, and if some problem emerges that is not within the therapist's scope of competence.

The usual minimal termination for an ongoing treatment process may require several sessions, but a satisfying termination to long-term treatment may require more than a month to complete. Should I decide to terminate therapy, I agree to schedule a final session with my therapist to discuss my decision and its implications.

Clients have the right to refuse or discontinue services at any time.

This agreement constitutes the entirety of our professional contract for psychotherapy services. Additions or changes must be made in writing and signed by both parties.

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

_____ _____
Legal Guardian Signature (For minors) Date